		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044792

Facility Name: Villa Scalabrini Nursing and Rehab

Address: 480 N. Wolf Road (Number) Northlake (City) 60164 (Zip Code)

County: Cook

Telephone Number: (708) 562-0040 **Fax #** (708) 562-3955

IDPA ID Number: 237061646008

Date of Initial License for Current Owners: 03/01/2000

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	52,704	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	30,012	3
4		Intermediate/DD			4
5	33	Sheltered Care (SC)	33	12,078	5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,794	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,153	8,299	6,480	35,932	8
9	SNF/PED					9
10	ICF	27,225	11,723		38,948	10
11	ICF/DD					11
12	SC	227	2,836		3,063	12
13	DD 16 OR LESS					13
14	TOTALS	48,605	22,858	6,480	77,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.22%

D. How many bed-hold days during this year were paid by Public Aid? N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 6,480

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	585,335	55,108	245	640,688		640,688		640,688			1
2	Food Purchase		426,522		426,522		426,522	(10,585)	415,937			2
3	Housekeeping	217,312	46,577	7,468	271,357		271,357		271,357			3
4	Laundry	174,811	57,083		231,894		231,894		231,894			4
5	Heat and Other Utilities			318,914	318,914		318,914		318,914			5
6	Maintenance	174,475	11,571	177,161	363,207		363,207		363,207			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,151,933	596,861	503,788	2,252,582		2,252,582	(10,585)	2,241,997			8
	B. Health Care and Programs											
9	Medical Director			14,996	14,996		14,996		14,996			9
10	Nursing and Medical Records	4,270,391	238,079	93,158	4,601,628		4,601,628	9,692	4,611,320			10
10a	Therapy	146,411	3,680	16,066	166,157		166,157		166,157			10a
11	Activities	174,230	3,861	8,111	186,202		186,202		186,202			11
12	Social Services	78,475	357	1,350	80,182		80,182		80,182			12
13	Nurse Aide Training											13
14	Program Transportation			448	448		448		448			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,669,507	245,977	134,129	5,049,613		5,049,613	9,692	5,059,305			16
	C. General Administration											
17	Administrative	90,483		899,981	990,464		990,464	(899,981)	90,483			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			5,651	5,651		5,651		5,651			20
21	Clerical & General Office Expenses	300,825	31,981	24,614	357,420		357,420	576,218	933,638			21
22	Employee Benefits & Payroll Taxes			2,026,227	2,026,227		2,026,227	73,918	2,100,145			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,039	4,039		4,039		4,039			24
25	Other Admin. Staff Transportation			1,643	1,643		1,643		1,643			25
26	Insurance-Prop.Liab.Malpractice			169,232	169,232		169,232		169,232			26
27	Other (specify):*											27
28	**TOTAL General Administration**	391,308	31,981	3,131,387	3,554,676		3,554,676	(249,845)	3,304,831			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,212,748	874,819	3,769,304	10,856,871		10,856,871	(250,738)	10,606,133			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Villa Scalabrini Nursing and Rehab #0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			661,748	661,748		661,748	75,734	737,482			30
31	Amortization of Pre-Op. & Org.			15,600	15,600		15,600		15,600			31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			36,836	36,836		36,836		36,836			35
36	Other (specify):*											36
37	**TOTAL Ownership**			714,184	714,184		714,184	75,734	789,918			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		978,197		978,197		978,197		978,197			39
40	Barber and Beauty Shops			2,512	2,512		2,512		2,512			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,074	124,074		124,074		124,074			42
43	Other (specify):* Nonallowable Costs			22,447	22,447		22,447	(22,447)				43
44	**TOTAL Special Cost Centers**		978,197	149,033	1,127,230		1,127,230	(22,447)	1,104,783			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,212,748	1,853,016	4,632,521	12,698,285		12,698,285	(197,451)	12,500,834			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(514)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,314)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,139)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(13,308)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (24,275)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(173,176)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (173,176)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (197,451)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Villa Scalabrini Nursing and Rehab

ID# 0044792

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Community relations expense	$ (6,013)	43	1
2	Radiology expense	(7,295)	43	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,308)		49

Villa Scalabrini Nursing and Rehab
Provider #: 0044792
07/01/2003 to 06/30/2004 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(514)	0	0	0	0	0	0	0	0	0	0	(514)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(514)	0	0	0	0	0	0	0	0	0	0	(514)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	9,692	0	0	0	0	0	0	0	0	0	9,692	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	9,692	0	0	0	0	0	0	0	0	0	9,692	16
	C. General Administration													
17	Administrative	0	(899,981)	0	0	0	0	0	0	0	0	0	(899,981)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,314)	577,532	0	0	0	0	0	0	0	0	0	576,218	21
22	Employee Benefits & Payroll Taxes	0	63,847	0	0	0	0	0	0	0	0	0	63,847	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,314)	(258,602)	0	0	0	0	0	0	0	0	0	(259,916)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,828)	(248,910)	0	0	0	0	0	0	0	0	0	(250,738)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	75,734	0	0	0	0	0	0	0	0	0	75,734	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	75,734	0	0	0	0	0	0	0	0	0	75,734	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(22,447)	0	0	0	0	0	0	0	0	0	0	(22,447)	43
44	**TOTAL Special Cost Centers**	(22,447)	0	0	0	0	0	0	0	0	0	0	(22,447)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(24,275)	(173,176)	0	0	0	0	0	0	0	0	0	(197,451)	45

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See Attached				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing supplies	$	Resurrection Health Care	100.00%	$ 9,692	$ 9,692	1
2	V	21	Other admin and general		Resurrection Health Care	100.00%	298,257	298,257	2
3	V	21	Clerical & data processing		Resurrection Health Care	100.00%	279,275	279,275	3
4	V	22	Employee benefits		Resurrection Health Care	100.00%	63,847	63,847	4
5	V	30	Depreciation		Resurrection Health Care	100.00%	75,734	75,734	5
6	V								6
7	V	17	Intercompany expense	899,981	Resurrection Health Care	100.00%		(899,981)	7
8	V	39	Intercompany pharmacy	978,197	Resurrection Health Care	100.00%	978,197		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,878,178			$ 1,705,002	$ * (173,176)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See Attached Schedule										2
3											3
4											4
5	Sister Elizabeth Tremczynski	Director	Management	0.00	111,240	< 1 hours	< 1%	N/A	0		5
6											6
7											7
8		Note: Sister Tremczynski is administrator of Holy Family Nursing & Rehabilitation Center, a related facility.									8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection Health Care/Med. Center
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 774-8000
Fax Number: (773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing supplies				$	$		$ 9,692	1
2	21	Other admin and general							298,257	2
3	21	Clerical & data processing							279,275	3
4	22	Employee benefits							63,847	4
5	30	Depreciation							75,734	5
6	39	Intercompany pharmacy							978,197	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,705,002	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

N/A

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Scalabrini Nursing and Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044792

CONTACT PERSON REGARDING THIS REPORT Lou Fragoso

TELEPHONE (773) 594-8556 FAX #: (773) 594-8567

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 195,174 B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 78,000 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 15,600 4. Dates Incurred: 2000

Nature of Costs: Organization Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	696,960	2000	$ 1,500,000	1
2					2
3	TOTALS	696,960		$ 1,500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	259		2000		$ 7,510,695	$ 254,093	35	$ 254,093	$	$ 1,098,364	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Illuminated display sign			2000	9,374	469	20	469		1,876	9
10	Redecorating			2001	6,181	309	10	309		1,238	10
11	Sign			2001	6,805	340	20	340		1,360	11
12	Roof repair			2001	4,246	212	20	212		848	12
13	Condensor			2000	2,185	109	20	109		436	13
14	Monitoring system			2000	1,592	80	20	80		320	14
15	Refrigeration service			2001	1,650	83	20	83		330	15
16	Air conditioning repair			2001	576	29	20	29		87	16
17	Display			2001	1,629	81	20	81		243	17
18	Kitchen floor			2002	625	31	20	31		93	18
19	Air conditioning repair			2002	744	37	20	37		111	19
20	Electrical wiring			2002	1,000	50	20	50		150	20
21	Roof repair			2001	614	31	20	31		93	21
22	Illuminated display			2001	4,199	210	20	210		630	22
23	Renovations			2002	2,385	119	20	119		357	23
24	Canopy			2002	2,100	105	20	105		315	24
25	Sewer line			2002	4,200	210	20	210		630	25
26											26
27											27
28	Reclass from moveable equipment:										28
29	Replace 20-ton Trane compressor			2002	7,791	779	10	779		1,169	29
30	Rewiring of emergency nurse call			2003	6,995	700	10	700		1,050	30
31	Patch foundation wall at handicap ramp			2003	19,850	1,323	15	1,323		1,985	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Door openers	2003	$ 7,876	$ 394	10	$ 394	$	$ 394	37
38	Replacement-Expansion joints	2003	14,347	717	10	717		717	38
39	Fiber optic system upgrade	2003	9,343	934	5	934		934	39
40	South wing renovation	2004	23,112	578	20	578		578	40
41	Replace drain pipes	2004	5,092	170	15	170		170	41
42	Corridor carpet	2004	2,128	71	15	71		71	42
43	Pressure guages (4)	2004	8,851	885	5	885		885	43
44	Bumper guards	2004	2,392	120	10	120		120	44
45	Network closet - Dietary	2004	5,761	115	25	115		115	45
46	Nurses call station	2004	56,945	2,847	10	2,847		2,847	46
47									47
48						75,734	75,734		48
49	Allocation from Resurrection Health Care								49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,731,283	$ 266,231		$ 341,965	$ 75,734	$ 1,118,516	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,986,702	$ 392,363	$ 392,363	$	10	$ 1,679,807	71
72	Current Year Purchases	47,617	3,154	3,154		5-15	3,154	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,034,319	$ 395,517	$ 395,517	$		$ 1,682,961	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$	$	$		$	76
77	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,265,602	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 661,748	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 737,482	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 75,734	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,801,477	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 36,836 Description: See attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Villa Scalabrini Nursing and Rehab
Provider #: 0044792
07/01/2003 to 06/30/2004 **Schedule 14A**

XII. RENTAL COSTS

B(16) - Rental Amount for movable equipment:

Description	Amount
Copier	8,833
Postage meter	2,846
Wound vacuum	6,178
Bed rental	17,412
Nursing equipment	707
Maintenance equipment	570
Dietary equipment	290
Total	36,836

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(1),(2),(3)	2047	hrs	$ 57,013	885	$ 13,274	$ 1,652	2,932	$ 71,939	1
2	Licensed Speech and Language Development Therapist	10A(1),(2),(3)	535	hrs	19,602	42	630	806	577	21,038	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1),(2),(3)	2369	hrs	69,796	17	1,034	1,222	2,386	72,052	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				978,197		978,197	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 146,411	944	$ 14,938	$ 981,877	5,895	$ 1,143,226	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Villa Scalabrini Nursing and Rehab
Provider #: 0044792
07/01/2003 to 06/30/2004 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,508,652	$ 1,508,652	1
2	Cash-Patient Deposits	46,577	46,577	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,404,247)	794,943	794,943	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	19,378	19,378	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,369,550	$ 2,369,550	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000	1,500,000	13
14	Buildings, at Historical Cost	7,510,695	7,510,695	14
15	Leasehold Improvements, at Historical Cost	220,588	220,588	15
16	Equipment, at Historical Cost	2,034,319	2,034,319	16
17	Accumulated Depreciation (book methods)	(2,801,477)	(2,801,477)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	78,000	78,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,600)	(67,600)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Brosato Museum	297,647	297,647	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,772,172	$ 8,772,172	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,141,722	$ 11,141,722	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 50,643	$ 50,643	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,078	52,078	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 102,721	$ 102,721	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to related parties	1,224,928	1,224,928	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,224,928	$ 1,224,928	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,327,649	$ 1,327,649	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,814,073	$ 9,814,073	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,141,722	$ 11,141,722	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,692,516	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,692,516	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(878,444)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (878,443)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,814,073	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,207,870	1
2	Discounts and Allowances for all Levels	(5,370,808)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,837,062	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	986,301	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 986,301	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,342	14
15	Telephone, Television and Radio	1,314	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,173,063	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21	19
20	Radiology and X-Ray		20
21	Other Medical Services	685,459	21
22	Laundry	75,754	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,946,953	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,397	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,397	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	44,128	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,128	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,819,841	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,252,582	31
32	Health Care	5,049,613	32
33	General Administration	3,554,676	33
	B. Capital Expense		
34	Ownership	714,184	34
	C. Ancillary Expense		
35	Special Cost Centers	1,003,156	35
36	Provider Participation Fee	124,074	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,698,285	40
41	**Income before Income Taxes (line 30 minus line 40)****	(878,444)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (878,444)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Villa Scalabrini Nursing and Rehab
Provider #: 0044792
07/01/2003 to 06/30/2004 **Schedule 19A**

XVII. INCOME STATEMENT
E (28) Other Revenue (specify):

Description	Amount
Cable TV	22,081
Activities income	472
Other	824
Donation	3,051
Transportation	5,295
Sisters House	12,405
	44,128

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,824	2,080	$ 76,802	$ 36.92	1
2	Assistant Director of Nursing	1,720	2,040	61,610	30.20	2
3	Registered Nurses	49,592	53,678	1,639,522	30.54	3
4	Licensed Practical Nurses	15,432	16,522	369,544	22.37	4
5	Nurse Aides & Orderlies	130,882	143,083	1,830,284	12.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,312	4,951	146,411	29.57	7
8	Rehab/Therapy Aides	6,745	7,332	92,461	12.61	8
9	Activity Director	2,030	2,197	31,649	14.41	9
10	Activity Assistants	10,480	11,972	142,581	11.91	10
11	Social Service Workers	6,400	6,590	78,475	11.91	11
12	Dietician	1,624	2,080	53,357	25.65	12
13	Food Service Supervisor	3,165	3,666	70,388	19.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	41,949	44,871	461,590	10.29	15
16	Dishwashers					16
17	Maintenance Workers	8,877	9,730	174,475	17.93	17
18	Housekeepers	20,854	22,639	217,312	9.60	18
19	Laundry	16,522	17,903	174,811	9.76	19
20	Administrator	2,120	2,248	90,483	40.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,335	18,653	300,825	16.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,014	2,182	31,984	14.66	31
32	Other Health Ca See Sch. 20A	7,747	8,724	168,184	19.28	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	350,624	383,141	$ 6,212,748 *	$ 16.22	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	14,996	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	1,128	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,124		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	447	$ 22,592	10(3)	50
51	Licensed Practical Nurses	1,612	61,274	10(3)	51
52	Nurse Aides	343	8,915	10(3)	52
53	TOTAL (lines 50 - 52)	2,402	$ 92,781		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Villa Scalabrini Nursing and Rehab
Provider #: 0044792 **Schedule 20A**
07/01/2003 to 06/30/2004

XVIII. A. STAFFING AND SALARY COST

Line 32 - Other Health Care

Description	Hours Worked	Hours Paid	Wages & Salary	Ave Hrly Wages
Director-Rehab Services	182	182	7,941	43.63
Resident Care Coordinator	3,789	4,342	67,150	15.47
Audiologist	21	21	560	26.67
Nurse Liaison	1,832	2,080	61,315	29.48
Inventory Coordinator	1,923	2,099	31,218	14.87
	7,747	8,724	168,184	19.28

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nick Papp	Administrator	0	$ 90,483
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,483

B. Administrative - Other

Description	Amount
Intercompany management fee	$ 899,981
(Eliminated in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 899,981
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
	N/A	
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,598
Unemployment Compensation Insurance	17,061
FICA Taxes	444,510
Employee Health Insurance	1,073,856
Employee Meals	10,071
Illinois Municipal Retirement Fund (IMRF)*	
Retirement	320,678
Employee Life Insurance	14,206
Employee Dental & Vision Insurance	44,884
Employee Morale & Other Benefits	1,163
Employee Disability Insurance	31,782
Employee Medical & Tuition Reimbursement	14,489
Home Office Allocation	63,847
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,100,145

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network of Illinois dues	4,615
Miscellaneous dues	525
Miscellaneous subscriptions	331
Miscellaneous liscenses & fees	180
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,651

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached	4,039
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,039

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Villa Scalabrini Nursing and Rehab
Provider #: 0044792
07/01/2003 to 06/30/2004 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	0
Allocated from Management Company	
Total (agree to Schedule V, line 19, column 8)	0

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing and Rehab # 0044792 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - 4,615**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **61,279** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **124,074**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,071** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Audit not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	585,335	55,108	245	640,688	0	640,688	0	640,688
2. Food Purchase	0	426,522	0	426,522	0	426,522	-10,585	415,937
3. Housekeeping	217,312	46,577	7,468	271,357	0	271,357	0	271,357
4. Laundry	174,811	57,083	0	231,894	0	231,894	0	231,894
5. Heat and Other Utilities	0	0	318,914	318,914	0	318,914	0	318,914
6. Maintenance	174,475	11,571	177,161	363,207	0	363,207	0	363,207
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,151,933	596,861	503,788	2,252,582	0	2,252,582	-10,585	2,241,997
9. Medical Director	0	0	14,996	14,996	0	14,996	0	14,996
10. Nursing & Medical Records	4,270,391	238,079	93,158	4,601,628	0	4,601,628	9,692	4,611,320
10a. Therapy	146,411	3,680	16,066	166,157	0	166,157	0	166,157
11. Activities	174,230	3,861	8,111	186,202	0	186,202	0	186,202
12. Social Services	78,475	357	1,350	80,182	0	80,182	0	80,182
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	448	448	0	448	0	448
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,669,507	245,977	134,129	5,049,613	0	5,049,613	9,692	5,059,305
17. Administrative	90,483	0	899,981	990,464	0	990,464	-899,981	90,483
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	0	0	0	0	0	0
20. Fees, Subscriptions & Promotion	0	0	5,651	5,651	0	5,651	0	5,651
21. Clerical & General Office	300,825	31,981	24,614	357,420	0	357,420	576,218	933,638
22. Employee Benefits & Payroll	0	0	2,026,227	2,026,227	0	2,026,227	73,918	2,100,145
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	4,039	4,039	0	4,039	0	4,039
25. Other Admin. Staff Trans	0	0	1,643	1,643	0	1,643	0	1,643
26. Insurance-Prop.Liab.Malpractice	0	0	169,232	169,232	0	169,232	0	169,232
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	391,308	31,981	3,131,387	3,554,676	0	3,554,676	-249,845	3,304,831
29. Total General Administrative	6,212,748	874,819	3,769,304	10,856,871	0	10,856,871	-250,738	10,606,133
30. Depreciation	0	0	661,748	661,748	0	661,748	75,734	737,482
31. Amortization of Pre-Op. & Org.	0	0	15,600	15,600	0	15,600	0	15,600
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	36,836	36,836	0	36,836	0	36,836
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	714,184	714,184	0	714,184	75,734	789,918
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	978,197	0	978,197	0	978,197	0	978,197
40. Barber and Beauty Shop	0	0	2,512	2,512	0	2,512	0	2,512
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	124,074	124,074	0	124,074	0	124,074
43. Other (specify):*	0	0	22,447	22,447	0	22,447	-22,447	0
44. Total Special Cost Ce	0	978,197	149,033	1,127,230	0	1,127,230	-22,447	1,104,783
45. Grand Total	6,212,748	1,853,016	4,632,521	12,698,285	0	12,698,285	-197,451	12,500,834

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,508,652	1,508,652
2. Cash - Patient Deposits	46,577	46,577
3. Accounts & Notes Recievable	794,943	794,943
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	19,378	19,378
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,369,550	2,369,550
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	1,500,000	1,500,000
14. Buildings, at Historical Cost	7,510,695	7,510,695
15. Leasehold Improvements, Historical Cost	220,588	220,588
16. Equipment, at Historical Cost	2,034,319	2,034,319
17. Accumulated Depreciation (book methods)	-2,801,477	-2,801,477
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	78,000	78,000
20. Accum Amort - Org/Pre-Op Costs	-67,600	-67,600
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	297,647	297,647
24. Total Long-Term Assets	8,772,172	8,772,172
25. Total Assets	########	11,141,722
CURRENT LIABILITIES		
26. Accounts Payable	50,643	50,643
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	52,078	52,078
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	0	0
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	102,721	102,721
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	1,224,928	1,224,928
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,224,928	1,224,928
46.Total Liabilities	1,327,649	1,327,649
47.Total Equity	9,814,073	9,814,073
48.Total Liabilities and Equity	########	11,141,722

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	14,207,870
2. Discounts and Allowances for all Levels	-5,370,808
Subtotal - Inpatient Care	8,837,062
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	986,301
7. Oxygen	0
Subtotal - Anciliary Revenue	986,301
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	11,342
15. Telephone, Television, and Radio	1,314
16. Rental of Facility Space	0
17. Sale of Drugs	1,173,063
18. Sale of Supplies to Non-Patients	0
19. Laboratory	21
20. Radiologyand X-Ray	0
21. Other Medical Services	685,459
22. Laundry	75,754
Subtotal - Other Operating Revenue	1,946,953
24. Contributions	0
25. Interest and Other Investments Income	5,397
Subtotal - Non-Operating Revenue	5,397
27. Other Revenue (specify):	0
28. Other Revenue (specify):	44,128
Subtotal - Other Revenue	44,128
30. Total Revenue	11,819,841
31. General Services	2,252,582
32. Health Care	5,049,613
33. General Administration	3,554,676
34. Ownership	714,184
35. Special Cost Centers	1,003,156
35. Provider Participation Fee	124,074
37. Other	0
40. Total Expenses	12,698,285
41. Income Before Income Taxes	-878,444
42. Income Taxes	0
43. Net Income or Loss for the Year	-878,444

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